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Reasons for Removal of the Norplant Contraceptive Device

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Abstract

Of those women at the Albuquerque Service Unit whose Norplant status was known (N=271), 100 (37%) had the device removed between 1992 and 1995. For those women where duration of use was known (N=92), the mean duration was 16.7 months. The most common reason for discontinuation was perceived weight gain.

Introduction

As one of the newest methods of family planning, levonorgestrel implants (Norplant) are being carefully evaluated both by women seeking a new method and health care providers counseling women. Previous articles in *The Provider*^{1,2} have addressed side effects of Norplant and reasons for Norplant removal. Concern over not being able to adequately screen women to "detect who will be 'good' and 'bad' candidates" for Norplant has been raised.² Even after counseling women about the benefits, risks, and side effects of Norplant, and giving them adequate time to decide before inserting the implants, many women return for removal of the implants because they cannot tolerate the side effects.

This investigation at the Albuquerque Service Unit was performed to evaluate the reasons for removal in a rather large and diverse population of American Indian Norplant users. We also looked at the duration of Norplant use in those women who had it removed, whether pregnancies occurred, and if the women who had discontinued Norplant were using another family planning method.

Methods and Materials

The population in this study was 319 American Indian women who had had the Norplant implant inserted in the Albuquerque Service Unit between 1992 and 1995. The population was obtained from the pharmacy's list of Norplant implants dispensed and by the Case Management System (part of the Indian Health Service Resource and Patient Management System).

To obtain consistent information from chart reviews, a chart abstract form was developed that included the chart number, date of insertion, facility responsible for insertion, date of removal, facility responsible for removal, reason(s) for the removal, if a pregnancy occurred after the removal, and current family planning method. The women's charts were reviewed, information was abstracted, and data were entered

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directly into a computer with "Epi Info" at the Albuquerque Indian Hospital.

Frequency percents and mean calculations were performed using "Epi Info." Reasons for having the Norplant removed were reviewed and frequencies determined.

Results

Among the 319 women who were known to have had the implant inserted in the Albuquerque Service Unit between 1992 and 1995, the status of the Norplant implants was unknown for 48 who were lost to follow up. Of the remainder (n=271), 100 (37%) were known to have had the Norplant removed (Table 1). The mean duration of Norplant use in the women who had the Norplant removed (n=92) was 16.7 months (SD±8.9); duration of Norplant use for the eight women who had it removed outside of the Albuquerque Service Unit was not indicated on the chart.

Reasons for removal of the Norplant implants were documented on the charts of 91 women. Reasons for removal were categorized, and frequencies are shown in Table 2. Because women often gave more than one reason for removal, the number of reasons totals more than 91.

The most common reasons for removal in this population were weight gain (30%), a desire for pregnancy (21%), irregular bleeding (21%), headaches (20%; one was documented as migraine), local irritation at the site of the implants (18%), mood changes (18%), heavy bleeding (12%), and acne (12%). Heavy bleeding and migraine headaches were the most medically significant side effects that women gave for having the Norplant removed. Five percent of the charts indicated that the women "just wanted it out"; 10% of the charts did not document a reason for removal of Norplant.

Twenty-four pregnancies were known to have occurred after removal of the Norplant; only three of these pregnancies occurred in women who had the implants removed because they wanted to get pregnant.

Of the 100 women who had the Norplant removed, subsequent family planning choices included oral contraceptives (n=38), injectable medroxyprogesterone (DepoProvera; n=19), condoms (n=16), surgical sterilization (n=6), and the intrauterine device (n=2). The medical records of 16 women indicated they were not using contraception, and the records of

Table 1. Outcome of Norplant in the Albuquerque Service Unit, 1992-1995.

Norplant continued	171	(54%)
Norplant removed	100	(31%)
Unknown	48	(15%)
Total	319	(100%)

Table 2. Reasons women in the Albuquerque Service Unit wanted the Norplant implants removed.*

Reason	Number
Weight gain	27
Wants pregnancy	19
Irregular bleeding	19
Headaches†	18
Local irritation	16
Mood changes	16
Heavy bleeding	11
Acne	11
Nausea	8
Wants oral contraceptives	8
Fatigue	5
Just "want it out"	5
Expulsion	4
No need	4
Hair loss	2
Dizzy	2
Religious reasons	1
Surgical sterilization	1
Joint pain	1
Hot flashes	1
Swelling	1
Anemia	1
Vomiting	1
Abdominal pain	1
Family disapproves	1
Infection	1
Ovarian cyst	1

* Nine charts had no reason documented for removal of the Norplant.
† One headache was documented as a migraine headache.

3 other women had no information about contraceptive use after Norplant removal.

Discussion

The rate of removal of Norplant at the Albuquerque Service Unit is similar to previous reports in Alaska and Phoenix.^{1,2}

Previous studies in Baltimore, Maryland³ and New York City⁴ found that although many women experienced side effects (such as irregular bleeding, weight gain, and headaches), adolescents, women who had previously had children, and women who had a previous contraceptive failure were more likely to tolerate these side effects and to be satisfied with the Norplant. Glantz⁵ found that a history of induced abortion identifies those teens most likely to retain the Norplant. These authors concluded that these groups of

women may be “good” candidates for Norplant. Glantz⁵ and Berenson,⁶ after reviewing records of adolescent women for side effects and patient satisfaction, have advocated that clinicians should consider Norplant as an appropriate birth control option for adolescents.

Adverse events in Norplant users have included infections, removal difficulties, stroke, thrombotic thrombocytopenia purpura, thrombocytopenia, and pseudotumor cerebri (with residual loss of peripheral vision). While these are rare occurrences and no causal relationship between Norplant and these adverse events has been established, physicians should advise patients of the possibility of these occurrences and should be cautious in implanting Norplant in patients with a history of or risk factors for these conditions.⁷ Since our population is already at risk for obesity and non-insulin-dependent diabetes mellitus, and since obesity may be a precursor for type II diabetes, weight gain is a potentially more serious adverse side effect than in other populations. We did not, however, document weight gain in our study. In addition, because the time period of our study was so short, we could not examine the possibility of weight gain contributing to diabetes.

Norplant can be offered as a family planning choice to most women in our population with an acceptable risk of medical side effects. As suggested by Attico,² Norplant registries should be kept, adequate counseling should be provided so that the patient understands risks and side effects, provisions should be made for expeditious removal of the Norplant upon

request from the patient, and the cost of the Norplant needs to be considered. This family planning method has many positive characteristics and therefore should be available to American Indian women throughout the Indian Health Service.

It is possible that the “weight gain” about which women complained was due to some other factor. We did not evaluate weight after Norplant removal or use a control group. Future studies should compare weight gain with Norplant to that in populations using other methods and no methods of contraception, and look at continuation rates relative to other methods of birth control.

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Using Television to Deliver Training in Tobacco Cessation to Health Care Workers in Rural Alaska

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Introduction

Alaska Natives (Indians, Eskimos, and Aleuts) are several times more likely to use tobacco than non-Natives in Alaska

or residents of the other 49 states.¹ Among Alaska Natives, the prevalence of smoking is higher in rural than in urban areas.¹

A distance education course, called "Tobacco Free Alaska" (TFA), was developed by the Chugachmiut Native Health Corporation with help from the Alaska Area Native Health Service, through a grant from the State of Alaska. TFA was designed to educate Alaska Natives about ways to stop tobacco use. Topics included (1) reasons why people smoke (or chew); (2) approaches to quitting; and (3) ways to prevent relapse. Supporting written material was compiled and made available in a small booklet.

TFA was televised over the publicly-funded Rural Alaska Telecommunications Network (RATNet) and included four taped, half-hour sessions and two live, one-hour sessions with opportunity for call-in questions. TFA was aired on six successive Sundays in March and April 1995. The time of day that the program aired was selected by RATNet.

Evaluations of TFA

Three different evaluations of the TFA were performed: (1) a telephone survey of a random sample of the general Alaska Native population, (2) a village survey performed by one of the authors (AS), and (3) a telephone survey of Community Health Aides/Practitioners in the State of Alaska.

For Alaska Natives residing in rural Alaska, Community Health Aides/Practitioners (CHA/Ps) are the primary health care providers. Over 400 such health aides serve 176 communities widely distributed throughout the state. The CHA/Ps are community residents who have received special training to provide acute, primary care medical services. One of the Healthy People 2000² objectives is to increase to at least 75% the proportion of primary care providers who routinely advise cessation and provide assistance and follow-up for patients who use tobacco. Community health workers who use tobacco themselves, as with other health care providers, however, may find it difficult to counsel their patients to quit.³

To help CHA/Ps reduce or cease their personal tobacco use, and acquire information they might share with their patients who use tobacco, an effort was made to encourage the CHA/Ps to view the TFA programs. Notices were sent by the TFA program director to each clinic, and a flyer was included to display at that site. This report presents data on the CHA/Ps' awareness of, participation in, and impressions about the program.

Methods

A telephone survey was conducted within a month of the last televised session of TFA; 90 potential respondents were randomly selected from a list of 455 active and alternate health aides. Questionnaires were sent by fax to health aides who were busy seeing patients or were not in the clinic at the time of the telephone call. Respondents were asked whether they had been notified in advance of the program, had watched at least one session of the series, and whether they

would like to see programs similar to TFA in the future.

Results

Of the sample of 90 CHA/Ps, responses were obtained from 53. Seventeen CHA/Ps could not be reached despite a number of telephone attempts, 11 no longer worked as CHA/Ps, 7 were away on personal leave, 1 had a nonworking phone number, and 1 declined to answer any questions. Thus, the response rate, based on active CHA/Ps only, was 67% (53/79).

Most of the respondents were female (87%), Eskimo (56%), and had a high school diploma or GED (56%). Their mean age was 41 years (range: 21-65 years). Forty percent were current cigarette smokers; 26% were using smokeless tobacco.

Sixty percent (n=32) of the respondents were aware of the program, and 34% (n=11) of those who were aware watched at least one session. All who watched at least one session of the program said they would like to see similar programs in the future.

Discussion

In Alaska, the time required to travel to a distant training site and the costs of transportation and lodging often make training health care providers difficult. The positive response of those who watched TFA suggests that distance education is a viable option.

Although awareness and participation rates described here are consistent with those reported elsewhere,⁴ the program directors were disappointed that a larger percentage of persons who were aware of the program did not watch it. When surveyed, a number of CHA/Ps offered unsolicited explanations for not watching TFA, including (1) being away from the community when the series was aired, (2) not having access to a television, (3) not being in the habit of watching television, and (4) preferring to watch another channel. Technical difficulties also contributed to lower participation; RATNet was not aired for several months just prior to the first session of TFA. Thus, television could not be used to promote the program, as had been planned.

These barriers to participation have practical implications. It is likely that better advertising, different scheduling (e.g., not showing the program on the weekends), and providing incentives for watching (e.g., giving continuing education credits) could improve participation in the future.

Overall, the results are encouraging and favor repeating the program to assess its impact on CHA/Ps' knowledge, attitudes, and behavior related to tobacco use. If judged successful, this program could be targeted toward broader audiences, such as other community providers (e.g., community health representatives, substance abuse counselors, and family health workers) and health care professionals.

Videotapes of the television sessions and the booklets covering all the information that was broadcast are available for use with other tobacco cessation/education efforts.

Requests for these materials and their costs or additional information about the program should be directed to Annette Siemens, MSN, FNP, Director, Community Health Aide Program, Chugachmiut Corporation, Box 2088, Seward, AK 99664.

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Summary of Respiratory System Diseases, FY 1994

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Introduction

This report presents the distribution of problems (or clinical impressions) relating to respiratory diseases as recorded by physicians and other providers of health care for patients treated in ambulatory care settings at Indian Health Service (IHS) and tribal direct and contract care facilities during fiscal year (FY) 1994.

The IHS and tribal direct care facility source document for the data presented are the Ambulatory Patient Care Report (IHS-406) and the Patient Care Component Ambulatory Encounter Record (IHS-803). For contract care, the source document is the Purchase/Delivery Order for Contract Health Services for Other than Hospital Inpatient or Dental (IHS-64). One of the above-mentioned forms is completed for every ambulatory medical care visit made to a direct or contract facility. The data shown in this report are combined totals from the computer-generated Ambulatory Patient Care (APC) System Report 1C and the Contract Health Services (CHS) System Report 3A.

It should be noted that the number of visits at tribally-operated facilities and visits contracted for by tribally-run CHS programs are not complete, because some tribes do not report through the IHS computer data systems; however the number of missing visits is thought to be small (i.e., less than 10% of the total).

The data in this report are tabulated by patient's age and

sex. The number of problems/clinical impressions does not equal the number of actual ambulatory care visits made to a facility because it is possible to record up to two significant problems or impressions during a single visit. Therefore, the total number of problems or impressions recorded is greater than the actual number of visits during the fiscal year.

Overall Leading Diagnostic Categories

The leading diagnostic category of problems/clinical impressions, at direct and contract facilities combined, in FY 1994, was the supplementary classification (e.g, well child care, physical examination, lab tests), with 1,200,335 impressions. This represented 14.2% of the total.

The second leading category was respiratory system diseases. This category had 961,245 impressions, or 11.4% of the total.

Details for the five leading major diagnostic categories are shown in Table 1.

Respiratory System Disease by Age and Sex

The data for distributions of clinical impressions of respiratory system diseases are considered from several different perspectives in Tables 2 and 3 and Figure 1.

Overall, females accounted for 59.0% of all respiratory system disease impressions. Interestingly, males outnumbered females in the youngest age groups (under 1 year, 1-4 years old). However, females had a higher number of impressions in each of the other age groups. There were more than twice as many female impressions as male impressions in the 25-44 and 45-64 year old age groups. In the 25-44 year old age group, 70.1% of the impressions were for females. In the 45-

Table 1. Number of ambulatory care clinical impressions (and percent of total) for the five leading diagnostic categories at Indian Health Service and tribal direct and contract facilities, FY 1994.

Diagnostic Category	Total	(%)	Direct	Contract
Supplemental classification*	1,200,335	(14.2)	1,175,848	24,487
RESPIRATORY SYSTEM DISEASES	961,245	(11.4)	922,646	38,599
Nervous system and sense organ diseases	818,739	(9.7)	781,118	37,621
Endocrine, nutritional and metabolic disorders	478,891	(5.7)	467,189	11,702
Pregnancy, childbirth, and puerperium	421,198	(5.0)	413,113	8,085
All other categories	4,571,379	(54.1)	4,313,260	258,119
Total, all categories	8,451,787	(100.0)	8,073,174	378,613

* Supplemental classification includes diagnoses such as well child care, physical examination, and laboratory tests.

Table 2. Number and percentage distribution of ambulatory care clinical impressions for respiratory system diseases, by sex and age, at Indian Health Service and tribal direct and contract facilities, FY 1994.

Age Groups	Total	Male (%)	Female (%)
Under 1 year	71,690	39,039 (54.5)*	32,651 (45.5)
1-4 years	165,969	86,263 (52.0)	79,706 (48.0)
5-14 years	194,764	94,200 (48.4)	100,564 (51.6)
15-24 years	111,420	40,619 (36.5)	70,801 (63.5)
25-44 years	219,610	65,683 (29.9)	153,927 (70.1)
45-64 years	135,477	41,988 (31.0)	93,489 (69.0)
65 + years	62,303	26,367 (42.3)	35,936 (57.7)
Age unknown	12	4 (33.3)	8 (66.7)
Total, all ages	961,245	394,163 (41.0)	567,082 (59.0)
Median age, years	19.3	12.6	25.0

* For example, 54.5% of all clinical impressions of respiratory system disease for children under 1 year of age were for males.

64 year old age group, the female percentage was 69.0.

The median age for a respiratory system clinical impression was 19.3 years, while the median age for all impressions in FY 1994 was 32.6 years. Figure 2 shows this graphically, and in addition shows the median ages for the three leading specific causes of respiratory system disease.

Nearly half (45.0%) of the respiratory system impressions were for pediatric patients, i.e., patients under 15 years old. This percentage is considerably higher than the pediatric percentage (26.1) for all clinical impressions in FY 1994.

The pediatric respiratory system impressions were nearly evenly divided between males (219,502) and females (212,921). However, male pediatric impressions accounted for

55.6% of the total male respiratory system impressions, while female pediatric impressions accounted for only 37.5% of the total for females. Thus, the average age for male respiratory impressions was much younger than the average female age. In fact, the median age of a male respiratory system disease impression (12.6 years) was half that of a female (25.0 years).

Specific Respiratory System Diseases

Specific conditions included under the respiratory system diseases category and distributions for these are illustrated in Table 4 and Figure 3.

Three of these conditions: upper respiratory infection including common cold (308,806 impressions); pharyngitis and tonsillitis (non-strep) (158,593); and respiratory allergy, asthma, and hay fever (146,652), each accounted for more than 15% of the total respiratory system disease impressions in FY 1994. Combined, these three causes accounted for 63.9% of the respiratory system disease category.

The remaining four specific causes overall ranged from 55,320 impressions for the acute bronchitis, bronchiolitis category to 8,945 for the chronic bronchitis, emphysema category. Added together, these four causes (112,484) accounted for fewer impressions than the third leading cause, respiratory allergy, asthma, and hay fever (146,652).

Specific Respiratory System Diseases by Sex

Females accounted for 567,081 (59%) of the total of 961,243 clinical impressions for respiratory system diseases in FY 1994, while males accounted for 394,162 (41%). As shown in Table 4, impressions for females outnumbered those for males in all seven specific respiratory system causes except pneumonia, and chronic bronchitis, emphysema; for both of these causes, males represented 50.1% of the total.

Females accounted for 181,360 (58.7%) of the upper respiratory infection impressions, the overall leading specific respiratory system cause. Among the pharyngitis and tonsillitis (the second leading respiratory system cause overall) impressions, females represented 60.2%; this was the highest percentage of the total for females except for the all other category.

Table 3. Percentage distribution of outpatient clinical impressions for respiratory system diseases, by age and sex, at Indian Health Service and tribal direct and contract facilities, and percentage of user population by age, FY 1994.

Age Groups	Respiratory System Diseases *			User Population
	Total	Male	Female	
Under 1 year	7.5	9.9	5.8	1.6
1-4 years	17.3	21.9	14.1	10.1
5-14 years	20.3	23.9	17.7	22.9
15-24 years	11.6	10.3	12.5	18.2
25-44 years	22.8	16.7	27.1	28.7
45-64 years	14.1	10.7	16.5	12.8
65 + years	6.5	6.7	6.3	5.6
Total, all ages	100.0	100.0	100.0	100.0

* For example, of all clinical impressions for respiratory system disease for males, 9.9% were for males under 1 year of age. While only 1.6% of the user population is under 1 year age, 7.5% of all clinical impressions for respiratory system diseases were for children in this age group.

Figure 1. Distribution of clinical impressions for respiratory system diseases, by age and sex, at IHS and tribal direct and contract facilities, FY 1994.

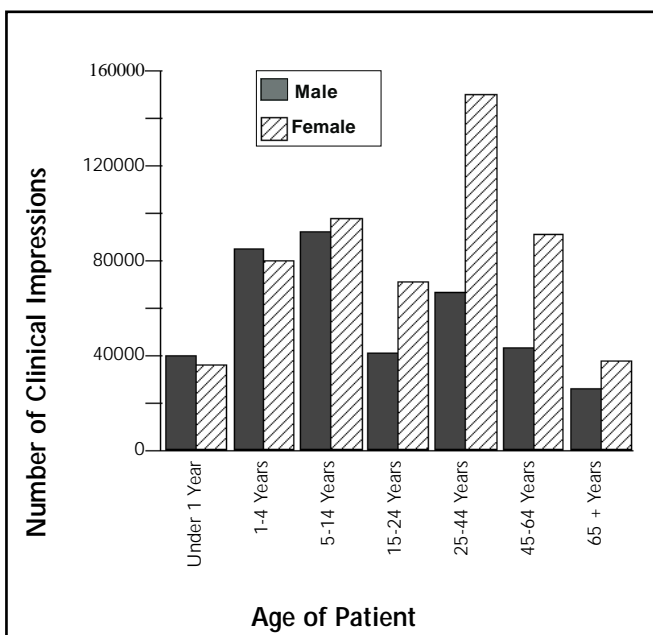


Figure 2. Median age (in years) for all clinical impressions, all respiratory system impressions, and impressions for the three leading specific respiratory system diseases, IHS and tribal direct and contract facilities, FY 1994.

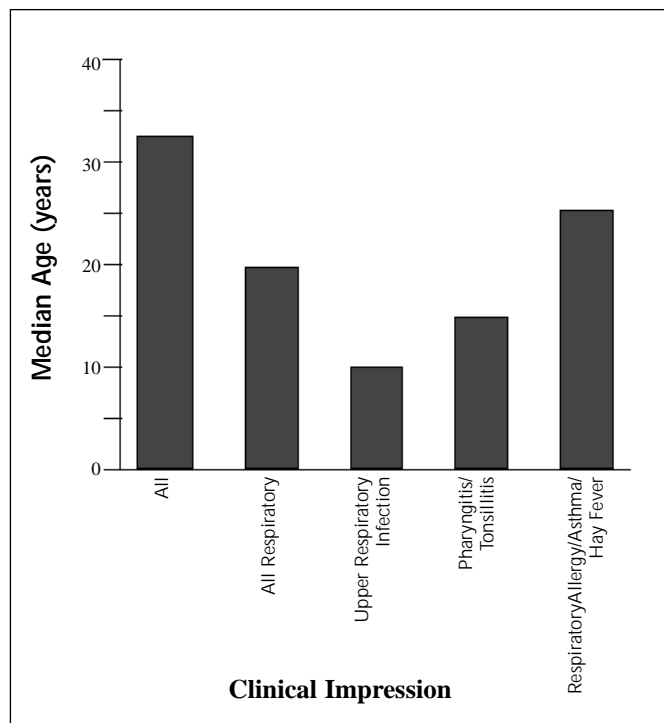


Figure 3. Distribution of clinical impressions for respiratory system diseases, IHS and tribal direct and contract facilities, FY 1994.

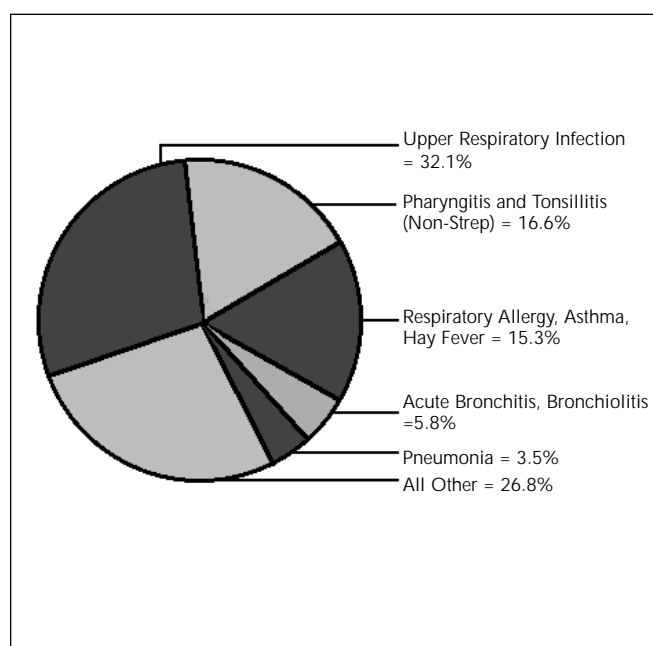


Table 4. Number and percentage distributions of clinical impressions for specific respiratory system diseases, by sex, in Indian Health Service and tribal direct and contract facilities, FY 1994.

Specific Condition	Number			Percent*			Percent†		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Upper respiratory infection, including common cold	308,806	127,446	181,360	32.1	32.3	32.0	100.0	41.3	58.7
Pharyngitis and tonsillitis (non-strep)	158,593	63,113	95,480	16.5	16.0	16.8	100.0	39.8	60.2
Respiratory allergy, asthma, hayfever	146,652	61,719	84,933	15.3	15.7	15.0	100.0	42.1	57.9
Acute bronchitis, bronchiolitis	55,320	24,458	30,862	5.8	6.2	5.4	100.0	44.2	55.8
Pneumonia	33,951	16,997	16,954	3.5	4.3	3.0	100.0	50.1	49.9
Influenza	14,268	6,043	8,225	1.5	1.5	1.5	100.0	42.4	57.6
Chronic bronchitis, emphysema	8,945	4,477	4,468	0.9	1.1	0.8	100.0	50.1	49.9
All other	234,708	89,909	144,799	24.4	22.8	25.5	100.0	38.3	61.7
Total	961,243	394,162	567,081	100.0	100.0	100.0	100.0	41.0	59.0
* For example, 32.1% of all clinical impressions for respiratory system diseases were for upper respiratory infections. Of all clinical impressions for respiratory system diseases for males, 16% were for pharyngitis and tonsillitis.									
† For example, of all clinical impressions of pharyngitis and tonsillitis, 39.8% were for males.									

centage of the total for females except for the all other category (61.7%).

Each of the specific causes accounted for similar percentages within the female and within the male categories. For example, upper respiratory infection accounted for 32.3% of the total male respiratory system impressions and

32% of total for females. The three leading specific causes accounted for 64% of the male impressions and 63.8% of the female impressions; in each case the three leading causes were upper respiratory infection; pharyngitis and tonsillitis; and respiratory allergy, asthma, and hay fever. ®

SPECIAL ANNOUNCEMENTS ®

Successful Managed Care Strategies

Successful Strategies for Increasing Direct Health Care Quality, Accessibility, and Economy for American Indians and Alaska Natives, recently published by the Indian Health Service, includes 16 articles describing outstanding examples of the application of managed care principles to direct care services in Indian health programs. The purposes of this publication are to (1) recognize and publicize these programs, (2) stimulate other innovative Indian health managed care efforts,

and (3) demonstrate to others that the Indian Health Service and tribal health programs are committed to managed care.

This publication has been distributed to all Indian health program facilities. If you cannot locate one at your facility, you can obtain a copy by contacting Anna Albert, Service Unit Director, Phoenix Indian Medical Center, 4212 North 16th Street, Phoenix, AZ 85016 (602-263-1567).

Training Available on Treatment of Abused Children

The Center on Child Abuse and Neglect at the University of Oklahoma Health Sciences Center, through funding from the National Center on Child Abuse and Neglect and the Indian Health Service (IHS), Mental Health Division, has established a training program to provide specialized training to IHS and tribal mental health professionals in the treatment of child physical and sexual abuse.

PROJECT: MAKING MEDICINE involves training IHS and tribal mental health professionals in a "training of trainers" model. Each professional will receive forty hours of training in treatment of child physical and sexual abuse, forty hours of training in supervision and consultation to assist other mental health professionals to increase their effectiveness to work with Indian child victims, weekly supervision and consultation, and quarterly on-site visits as follow-up to training and supervision.

The training is specific to American Indian populations and their unique characteristics. Training consultants include

traditional American Indian Healers. The core faculty are Child Clinical and Counseling Psychologists who have expertise in treatment of child maltreatment. Two psychologists are also American Indian.

Funding is available for 60 mental health professionals to be trained over the next three years from the twelve IHS Areas. Each year IHS will select 20 professionals from 4 IHS Areas to participate in the training. Each IHS Area has five training slots to fill.

Licensed tribal and IHS Mental Health professionals (PhD, LMSW, LPC) are encouraged to contact their respective IHS Mental Health Branch Chief to be nominated. Certified Alcohol and Drug Counselors who work with adolescents may also be considered for training slots.

For additional information regarding PROJECT: MAKING MEDICINE, please contact Dolores Subia BigFoot, PhD, Center on Child Abuse and Neglect, CHO 4B138, P.O. Box 26901, Oklahoma City, OK 73190 (phone: 405-271-8858; fax: 405-271-2931; Internet: peds-abuse@uokhsc.edu).

MEETINGS OF INTEREST ®

Medical Aspects of Addiction Conference November 18-22, 1996 Panama City, Florida

The Second Annual Nashville Area Alcohol and Substance Abuse Program, Medical Aspects of Addiction Conference will be held November 18-22, 1996 in Panama City, Florida. Topics will include pharmacological trends; neurobiology of craving; nutritional diagnosis in addictions; building and implementing multidisciplinary teams; alternative medicine in treatment and addiction; and cultural and traditional components of therapy.

The meeting will be held at the Marriott Bay Resort in Panama City, Florida. For more information contact Mr. Jim Mills at the Cherokee Health Delivery System, Cherokee, North Carolina 28719 (phone: 704-497-9485).

NIDDM in Minority Youth December 6-7, 1996 Tucson, AZ

The Native American Research and Training Center (NARTC) and the Office of Minority Health are cosponsoring a conference on the problem of non-insulin-dependent diabetes mellitus (NIDDM) in youth. Topics will include: epidemiology of NIDDM in children and adolescents of Native American, African American, and Hispanic heritage; diagnostic criteria for NIDDM in youth; risk factors for NIDDM in these populations; treatment protocols and the use of medications in the treatment of NIDDM in youth; research priorities; the economic impact of NIDDM in youth; and primary and secondary prevention of NIDDM in youth, with particular attention to sociocultural issues.

The meeting will be held at the Hotel Park in Tucson, Arizona. For further information, contact the program coordinator at NARTC, 1642 East Helen Street, Tucson, AZ 85719 (phone: 520-621-5075).

NCME VIDEOTAPES AVAILABLE ®

Health care professionals employed by Indian health programs may borrow videotapes produced by the Network for Continuing Medical Education (NCME) by contacting the IHS Clinical Support Center, 1616 East Indian School Road, Suite 375, Phoenix, Arizona 85016.

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the AMA Physician's Recognition Award. These CME credits can be earned by viewing the tape(s) and submitting the appropriate documentation directly to the NCME.

To increase awareness of this service, new tapes are listed in The IHS Provider on a regular basis.

NCME # 697: Dermatology Edition

Cutaneous Manifestations of Lyme Disease (12 minutes)

There are a variety of skin diseases associated with the bite of the deer tick, which transmits the *Borrelia burgdorferi* organism. Dr. Donald C. Abele discusses ECM (erythema chronicum migrans), the skin disorder most commonly seen in Lyme disease and other *borrelia*-associated disorders.

Topical Vitamin C as Protection Against UV Exposure: A Preliminary Report (7 minutes) Research results are promising regarding the UV protective effects of vitamin C used topically. Traditional sunscreens tend to be irritating, and may not provide enough protection.

Prevention of Poison Ivy and Poison Oak (7 minutes) Poison ivy and poison oak are the most common causes of allergic contact dermatitis in North America. Join Dr. Epstein as he provides a comprehensive guide to prevention, including proper plant identification, patient education materials, protective clothing, available treatments, and desensitization.

Chronic Actinic Dermatitis (7 minutes) Chronic actinic dermatitis is a group of photosensitivity diseases of a chronic nature. The spectrum begins with chronic photocontact dermatitis, continues to include persistent photosensitivity to systemic agents, and photosensitive exzema. It ends with actinic reticuloid as the most severe form of expression.

NCME #698: Topics in Oncology

Magnetic Resonance Imaging: Clinical Uses in Oncology (12 minutes) Dr. Joseph A. Frank provides a review of how MRI is used to detect various types of malignancies and discusses future developments for this increasingly valuable diagnostic procedure.

Stem Cell Factor: A New Hematopoietic Cytokine (8 minutes) A new hematopoietic growth factor produced by stromal cells has been identified and determined to be the ligand for the c-kit cell surface receptor. This interaction is an important component in the development of hematopoietic stem cells.

The Changing Status of Bone Marrow Transplantation for Lymphoma (8 minutes) Bone marrow transplantation is an

increasingly applied treatment for patients with cancer, and the lymphomas are the most common disease treated this way. Dr. James O. Armitage reviews how this procedure is being used for lymphoma.

Apoptosis: The Role of the APO-1/FAS (CD95) System in Lymphoproliferation, Leukemia, and Hematopoietic Failure (18 minutes) Apoptosis is the in-built program in each cell that tells it when to die. Dr. Klaus-Michael Debatin discusses this and its potential clinical applications.

NCME #699

Towards Vascular Integrity (45 minutes) Most of the cardiovascular, heart, and kidney diseases have the blood vessel as the primary culprit. This program reports on current thinking in vascular integrity – that is, the steps required to preserve or restore the intrinsic role of the endothelium and vascular wall in terms of normal (variable) tone, growth, and hemostasis. The concept that endothelial dysfunction underlies the development of many vascular diseases, especially atherosclerosis, is now well accepted. Thus, this review is divided into four themes: (1) the normal role of the endothelium, (2) endothelial dysfunction and the Fatty Streak as precursors of atherosclerosis, (3) Why does the stable plaque become unstable?, and (4) How to protect the endothelium; the basis for the MIDAS study. One of the groups of drugs that might achieve this is the Ca²⁺ antagonists. A scheme with the specific sites of action and the current understanding of mechanisms repeats itself throughout the program.

NCME #700

Psychiatric Challenges for the Primary Care Physician: Panic Disorder (60 minutes) Patients with panic disorder frequently undergo repeated, unproductive, and expensive clinical evaluation before the cause of their symptoms is identified. This is unfortunate, because, as Dr. Jerrold F. Rosenbaum demonstrates, uncomplicated panic disorder is easily diagnosed and treated. Two standardized cases are presented to illustrate an efficient, and effective, approach to the management of panic in a primary care setting.

NATIVE AMERICAN MEDICAL LITERATURE®

The following is an updated MEDLINE search on Native American medical literature. At the end of each cited article, you will find a unique identifying (UI) number. For those of you who may wish to obtain a copy of a specific article, this can be facilitated by giving the librarian nearest you the UI number as well as the complete citation.

If your facility lacks a library or librarian try calling your nearest university library, the nearest state medical association, or the National Library of Medicine (1-800-272-4787) to obtain information on how to access journal literature within your region. Bear in mind that most local library networks

function on the basis of reciprocity and, if you do not have a library at your facility, you may be charged for services provided.

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